Part C. State Plan

Section I. Description of State Service System

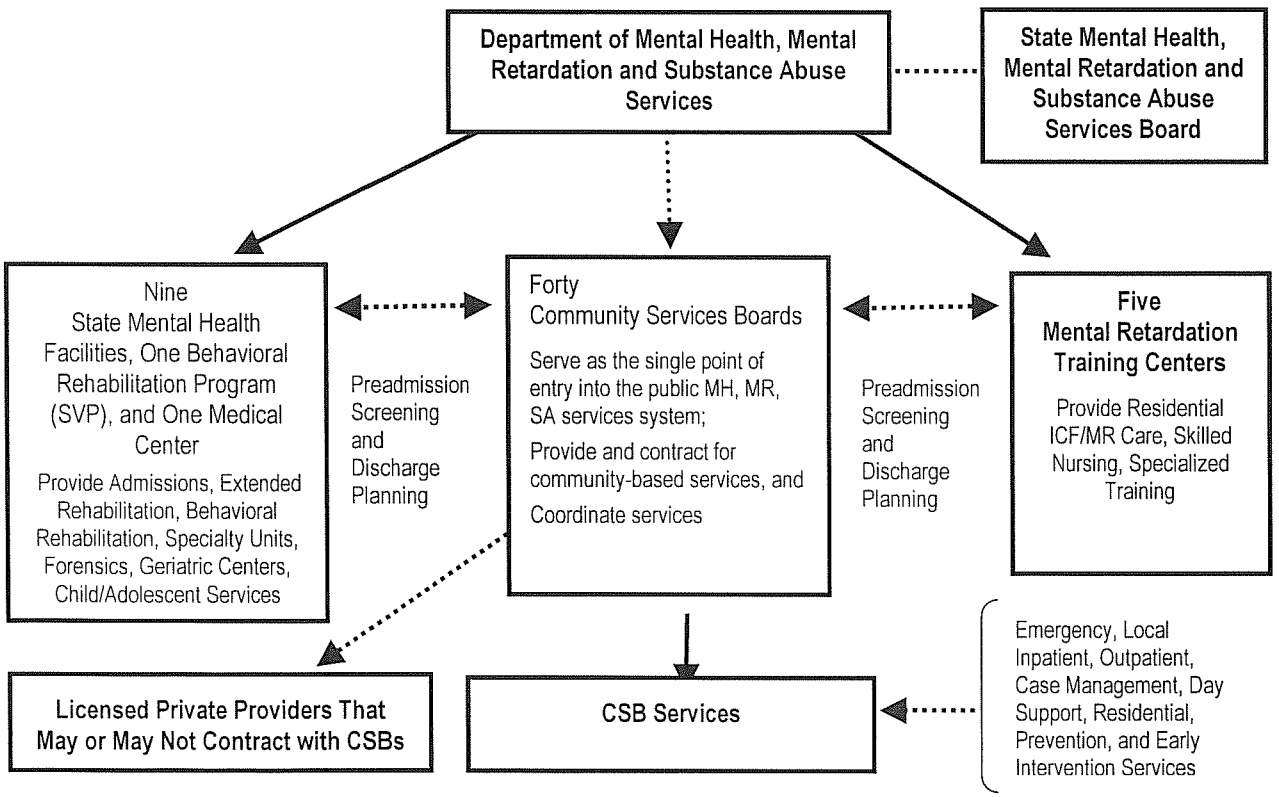
This information is primarily excerpted from Virginia's Comprehensive State Plan 2006-2012. The Code of Virginia at 37.1-48.1 requires the Department of Mental Health, Mental Retardation and Substance Abuse Services to develop and update biennially a six-year Comprehensive State Plan for mental health, mental retardation and substance abuse services. The same code section requires that the plan be used in the preparation of the Department's biennium budget submission to the Governor. The Comprehensive State Plan provides an excellent and thorough background against which to understand the state's mental health plan in the context of the broader system.

A. Overview of Virginia's Mental Health System

Services System Overview and Structure

Virginia's public services system includes the Department, the State Mental Health, Mental Retardation, and Substance Abuse Services Board (the State Board), 16 state mental health and mental retardation facilities, and 40 community services boards (CSBs) that may provide services directly or through contracts with private providers.

The following diagram outlines the current relationships between these system components. Solid lines depict a direct operational relationship between the involved entities (e.g., the Department operates the state facilities). Broken lines depict non-operational relationships (e.g., policy direction, contracting, or coordination).



Statutory Authority, Mission, and Responsibilities of the Department and State Board

Title 37.2 of the *Code of Virginia* establishes the Department as the state authority for alcoholism, drug abuse, mental health, and mental retardation services. By statute, the State Board offers policy direction for Virginia's services system.

The mission of the Department's Central Office is to provide leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance use disorders (alcoholism and other drug addiction). It seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals.

Responsibilities of the Department include:

- Providing leadership that promotes strategic partnerships among and between CSBs, state facilities, other services system partners, and the Central Office;
- Providing direct care, treatment, and habilitation services in state mental health and mental retardation facilities (civil and forensic services);
- Supporting the provision of accessible and effective community mental health, mental retardation, and substance abuse treatment and prevention services through a network of CSBs;
- Assuring that public and private mental health, mental retardation, and substance abuse services providers adhere to licensing standards; and
- Protecting the human rights of individuals receiving of mental health, mental retardation, and substance abuse services.

Characteristics of CSB Mental Health Services

Eligibility for mental health services provided by CSBs is determined by clinical criteria for each local program. Emergency services are available to anyone in the geographic area served by the CSB, while other services are generally targeted to residents of the CSB service area. In FY 2004, 106,376 individuals received CSB mental health services. This represents an unduplicated count of all individuals receiving any mental health services. Numbers of individuals receiving mental health services by core service follows.

Number of Individuals Receiving CSB Services by MH Core Service in FY 2004

Core Service	# Served	Core Service	# Served
Emergency Services	42,786	Supported Employment - Group Models	62
Local Inpatient Services	1,830	Alternative Day Support Arrangements	198
Outpatient Services	72,823	**TOTAL Day Support Services**	10,077
Intensive In-Home	2,408	Highly Intensive Residential	294
Case Management	43,537	Intensive Residential	182
Assertive Community Treatment	486	Supervised Residential	1,282
TOTAL Outpatient & Case Management	119,254	Supportive Residential	4,874
Day Treatment/Partial Hospitalization	439	Family Support	122

Core Service	# Served	Core Service	# Served
Therapeutic Day Treatment - C&A	1,381	**TOTAL Residential Services**	6,754
Rehabilitation Services	5,634	**Early Intervention Services**	695
Sheltered Employment Services	51	**TOTAL Individuals Served**	181,396
Supported/Transitional Employment	2,312	**TOTAL Unduplicated Individuals**	109,175

Source: 2005 Overview of Community Services Delivery in Virginia, June 1, 2005, Department.

Notes: TOTAL Individuals served are not unduplicated numbers because some individuals receive more than one type of service and sometimes receive services in more than one program area.

Characteristics of State Hospitals and Training Centers and Trends

State Hospitals

State hospitals provide highly structured intensive inpatient services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. Specialized programs are provided for geriatric, child and adolescent, and forensic individuals. The Joint Commission for Accreditation of Healthcare Organizations (JACHO) has accredited all state hospitals. Child and adolescent services provided by the Southwestern Virginia Mental Health Institute and the Commonwealth Center for Children and Adolescents (CCCA) are licensed under the CORE regulations for residential children's services. The Hiram Davis Medical Center (HDMC) provides medical and skilled nursing services to individuals receiving state facility services. A new behavioral rehabilitation facility, the Virginia Center for Rehabilitative Services (VCBR) opened in October 2003. This facility provides individualized rehabilitation services in a secure facility to individuals who are civilly committed as sexually violent predators.

Operating (staffed) bed capacities for the state hospitals follow.

Mental Health Facility Operating Capacities – June 30, 2005

MH Facility	# Beds	MH Facility	# Beds	MH Facility	# Beds
Catawba Hospital	120	Eastern State Hospital	481	Southern VA MHI	72
Central State Hospital	277	Northern VA. MHI	127	Southwestern VA MHI	172
CCCA	48	Piedmont Geriatric	135	Western State Hospital	254
TOTAL OPERATING CAPACITY (BEDS)					1,686

Note: HDMC, with an operating capacity of 74 beds, and VCBR, with an operating capacity of 36 beds, are not included in this table.

The average daily census by facility follows.

Mental Health Facility Average Daily Census (ADC) – FY 2005

MH Facility	ADC	MH Facility	ADC	MH Facility	ADC
Catawba Hospital	100	Eastern State Hospital	409	Southern VA MHI	69
Central State Hospital	244	Northern VA. MHI	123	Southwestern VA MHI	143

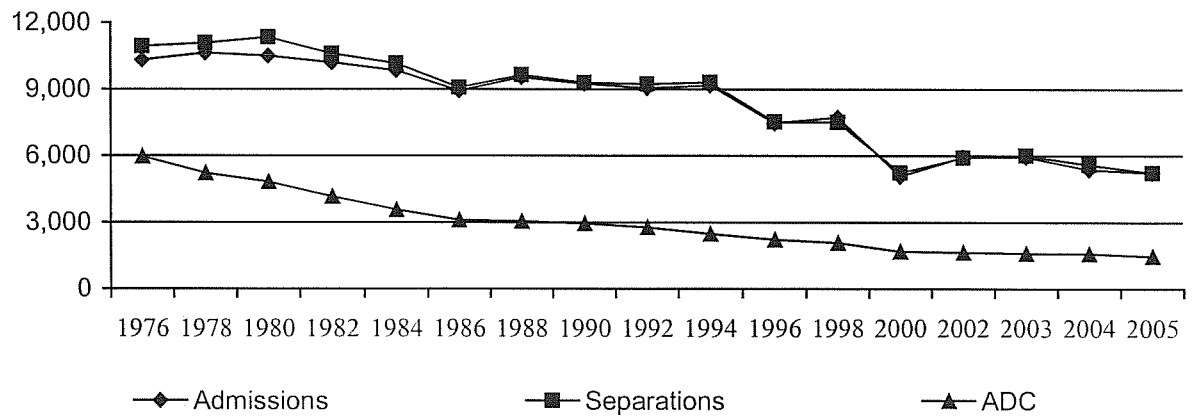
CCCA	29	Piedmont Geriatric	118	Western State Hospital	243
TOTAL STATE MH FACILITY AVERAGE DAILY CENSUS					1,478

Note: HDMC, with an ADC of 67, and VCBR, with an ADC of 12, are not included in this table

Between FY 1976 and FY 1996, the average daily census at state hospitals, excluding the Hiram Davis Medical Center, declined by 3,745, or 63 percent (from 5,967 to 2,222). Between FY 1996 and FY 2005, the average daily census declined by 33 percent (from 2,222 to 1,478). Between FY 1996 and FY 2005, excluding the Hiram Davis Medical Center and the Virginia Center for Behavioral Rehabilitation, admissions declined by 30 percent (from 7,468 to 5,232) and separations (discharges) declined by 30 percent (from 7,529 to 5,236).

Admission, separation, and average daily census trends (FY 1976 - FY 2005) for state hospitals, excluding the Hiram Davis Medical Center and the Virginia Center for Behavioral Rehabilitation, follow.

MH Facility Admissions, Separations, and Average Daily Census (ADC) Trends: FY 1986 - FY 2005

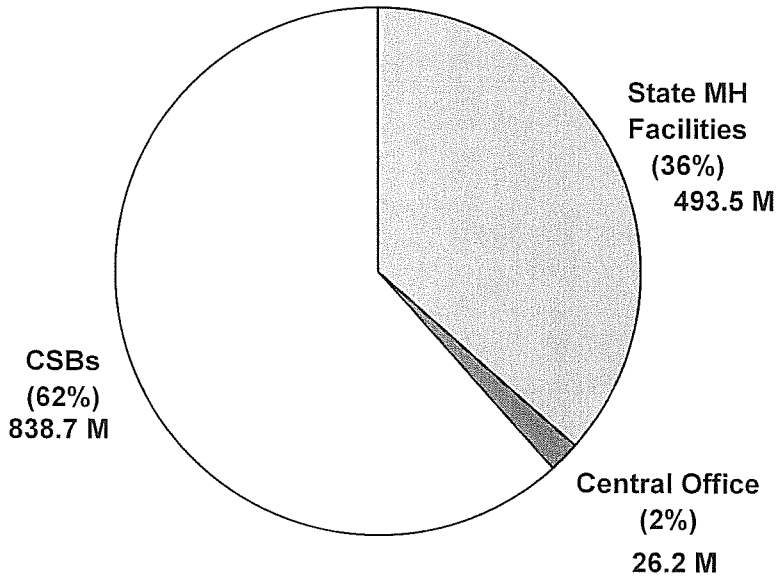


Note: Includes the Virginia Treatment Center for Children through FY 1991, when it transferred to the Medical College of Virginia.

Services System Funding

FY 2004 Total Services System Funding

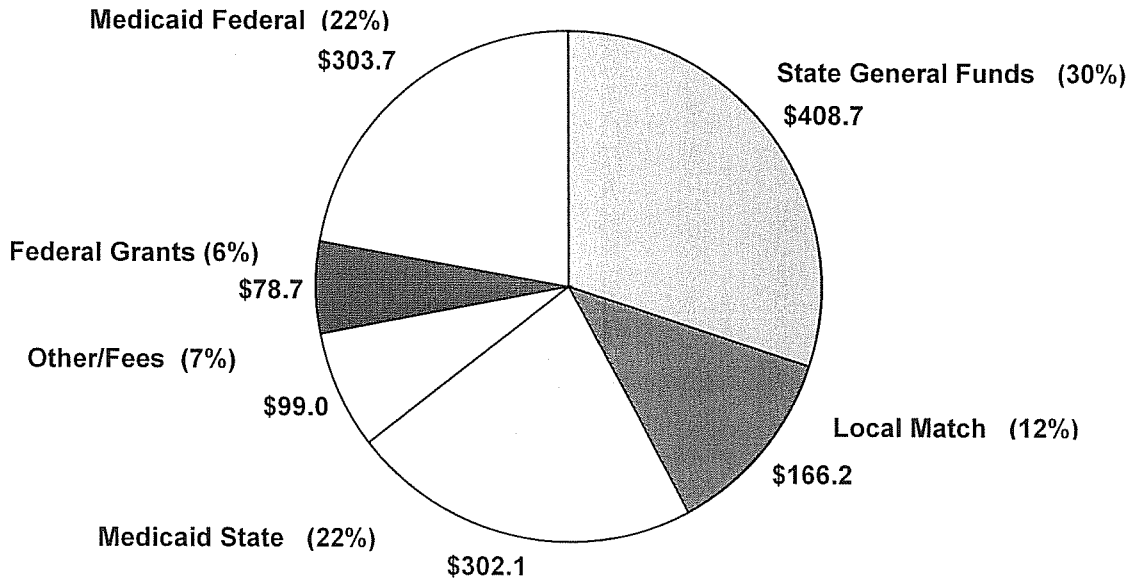
$1.358 Billion



Dollars Above Are in Millions

FY 2004 Total Services System Funding

$1,358.4 Million



Dollars Above Are in Millions

Summary of Areas Needing Attention

Current and Future Service Needs

CSB Waiting Lists

The following table displays the number of Virginians who were on CSB waiting lists for community mental health services during the first three months of 2005.

Numbers of Individuals on CSB Waiting Lists for Mental Health Services in April 2004

Population	Number Receiving Some CSB Services	Number NOT Receiving Any CSB Services	Total on CSB Waiting List
Adults with Serious Mental Illnesses	3,554	811	4,365
Children & Adolescents With or At Risk of Serious Emotional Disturbance	1,377	625	2,002
Total MH	4,931	1,436	6,367

To be included on the CSB waiting list for CSB services, an individual had to have sought the service and been assessed by the CSB as needing that service. CSB staff also reviewed their active cases to identify individuals on their active caseloads who were not receiving the amounts or types of services that they needed. This point-in-time methodology for documenting unmet service demand is conservative because it does not identify the number of persons who needed services over the course of a year.

State Mental Health Facility Discharge Lists

There are currently 109 patients in state mental health facilities whose discharges have been delayed due to extraordinary barriers.

Children Receiving Special Education Services

According to the Virginia Department of Education, based on counts made on December 1, 2004, there were 12,795 students with a primary disability (as defined by special education law) of emotional disturbance and 13,269students with mental retardation receiving special education services. Included in this count were students in a local school division, in either of the two schools for the deaf and the blind, in a state mental health or mental retardation facility, and in a private day or residential placement made by the school division or Comprehensive Services Act team. These numbers do not include children who are not receiving special education services. Also not included are students in private placements made by the parents or children educated by the Department of Correctional Education. As these students age out of special education services, many will require community-based treatment or habilitation services to maintain the skills they learned in special education.

CRITICAL ISSUES AND STRATEGIC RESPONSES

Transforming Virginia's System of Care

Integrated Strategic Plan for Virginia's Services System

The Department's Integrated Strategic Plan (ISP), *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation, and Substance Abuse Services System*, (2005) outlines a framework for transforming Virginia's publicly funded mental health, mental retardation, and substance abuse services system to:

- Fully implement self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policies and practices that reflect the unique circumstances of individuals with one or more of the following: mental illnesses, mental retardation, or substance abuse disorders.
- Incorporate the principles of inclusion, participation, and partnerships into daily operations at all levels.
- Expand services and supports options needed to support individual and family choice, community integration, and independent living.
- Provide sufficient capacity to meet growing individual needs so that individuals with mental illnesses, mental retardation, or substance use disorders, wherever they live in Virginia:
  - Receive the levels of services and supports they need,
  - When and where they need them,
  - In appropriate amounts, and
  - For appropriate durations.
- Promote the health of individuals receiving services, families, and communities.
- Increase opportunities for collaboration among state and community agencies.
- Align administrative, funding, and organizational processes to make it easier for individuals and families to obtain the services and supports they need.
- Monitor performance and measure outcomes to demonstrate that services and supports are appropriate and effective, promote services system improvement, and consistently report on the transformation process.
  - Provide stewardship and wise use of system resources, including funding, human resources, and capital infrastructure, to assure that services and supports are delivered in a manner that is efficient, cost-effective, and consistent with evidence-based and best practices.

Vision for the Future Services System in Virginia

The Department is committed to implementing the vision "of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of individual participation in all aspects of community life, including work, school, family and other meaningful relationships" (State Board Policy 1036 (SYS) 05-3).
State and local government have a collective responsibility for assuring the provision of a "safety net" of appropriate services and supports in safe and suitable settings for individuals with mental illnesses, mental retardation, or substance use disorders who are in crisis or who have severe or complex conditions, or both, and cannot otherwise access needed services and supports because of their level of disability, their inability to care for themselves, or their need for a structured or secure environment.

Multi-Agency MH Transformation Initiative

The Department is proposing a Mental Health Transformation Initiative to support planning and infrastructure development activities that are intended to result in comprehensive, cross-agency

transformation of the state mental health system. This initiative would build upon the work of the Regional Partnerships and Special Population Workgroups. Through this initiative, the Department would work with the agency heads and senior leadership of the Department, the Department of Rehabilitative Services, the Department of Social Services, the Department of Medical Assistance Services, the Department of Corrections, the Department of Juvenile Justice, and the Department of Housing and Community Development; the Chair of the CSA State Executive Council; and the Inspector General for Mental Health, Mental Retardation, and Substance Abuse Services to develop a comprehensive cross-agency mental health plan to transform Virginia's mental health services system by addressing the six goals and 19 recommendations of the President's New Freedom Commission report, *Achieving the Promise*, with action steps and outcome measures. The comprehensive cross-agency mental health plan will be compatible with the Department's Integrated Strategic Plan and its Comprehensive State Plan. Its development process will be a broad, statewide, participatory process that also will include individuals receiving services, family members, advocates, public and private providers, local government representatives, and other interested stakeholders.

Critical Success Factors

Seven critical success factors described below are required to transform the current services system's "crisis-response" orientation to one that provides incentives and rewards for implementing the vision of a recovery and resilience-oriented and person-centered system of services and supports. Successful achievement of these critical success factors will require the support and collective ownership of all system stakeholders.

1. Virginia successfully implements a recovery and resilience-oriented and person-centered system of services and supports.
2. Publicly funded services and supports that meet growing mental health, mental retardation, and substance abuse services needs are available and accessible across Virginia.
3. Funding incentives and practices support and sustain quality care focused on individuals receiving services and supports, promote innovation, and assure efficiency and cost-effectiveness.
4. State facility and community infrastructure and technology efficiently and appropriately meet the needs of individuals receiving services and supports.
5. A competent and well-trained mental health, mental retardation, and substance abuse services system workforce provides needed services and supports.
6. Effective service delivery and utilization management assures that individuals and their families receive services and supports that are appropriate to their needs.
7. Services and supports meet the highest standards of quality and accountability.

Goals, Objectives, and Action Steps

Goal 1: Successfully implement a recovery and resilience-oriented and person-centered system of services and supports.

Objectives:

1. *Create awareness and understanding of recovery and resilience-oriented and person-centered principles and practices.*
2. *Publicize the commitment of services system leaders to recovery and resilience-oriented and person-centered principles and practices.*
3. *Transform current services system policies and regulations, incentives, service structures, and practices to support implementation of a recovery and resilience-oriented and person-centered system of care.*

B. *Implementation of Self-Advocacy, Self-Determination, Recovery, Resilience, and Person-Centered Principles and Practices*

Mental Health

The Virginia mental health system has been enhanced and improved through the involvement of well-informed individuals and their families. Such involvement at all levels of the services system has been and continues to be a priority of the Department. Federal Mental Health Block Grant funds are used to support numerous activities across the state to educate individuals and their families about mental illnesses and treatments. These activities have been accomplished through contracts with the

- Virginia Human Services Training Center ($74,928) to train individuals receiving services as peer counselors;
- National Alliance for the Mentally Ill (NAMI)-Virginia to provide statewide education to individuals and their families ($50,000);
- Mental Health Association of Virginia to provide Consumer Empowerment Leadership Training (CELT) Leadership Academy training ($75,000);
- Parents and Children Coping Together (PACCT) to educate parents and caregivers of SED children across the state ($75,000);
- Virginia Organization of Consumers Asserting Leadership (VOCAL) to provide technical assistance to peer-run programs ($62,718), VOCAL's Reach initiative to provide Wellness Recovery Action Plan training ($50,000), and VOCAL's Consumer Network to build and strengthen a statewide peer network ($75,000);
- Contracts with six peer-run programs across the state to provide peer-operated programs and centers ($291,860);
- Family Support Services Project ($32,500) in southwest Virginia; and
- Southwest Virginia Consumer and Family Involvement Project ($42,500).

Goal 2: Increase opportunities for individual and family involvement.

Objectives:

1. *Maintain current avenues for individual and family involvement, while seeking to widen the scope of individual involvement in all aspects of the mental health system.*

   Action Steps:

Goal 3: Improve opportunities for individual and family education and training.

Objectives:

1. *Increase the number of individuals and family members who receive training.*

Goal 4: Promote and support the implementation of mental health programs that foster empowerment, peer support, and recovery-based services.

Objectives:

1. *Collaborate with the Mental Health Planning Council and other services system partners to transform the current system of services and supports toward a recovery orientation.*

   Action Steps:

2. *Promote the establishment and expansion of peer-run programs throughout the state.*

Goal 5: Provide individuals and families with the opportunity, at the systems and individual levels, to determine the types of mental retardation services and supports they receive and to evaluate the quality of those services.

Objectives:

1. *Expand the number of individuals receiving services and families involved in the planning process.*

   Action Steps:

2. *Assure greater opportunities for individual and family direction in their own services.*

   Action Steps:

Goal 6: Reduce the stigma and shame associated with substance use disorders that inhibit people with substance use disorders from seeking help and restrict available resources to support treatment and prevention and increase the impact of individual experience on the service delivery system.

Objectives:

1. *Facilitate the development and growth of the Substance Abuse and Addiction Recovery Alliance (SAARA) as a fiscally independent organization with a strong, viable membership.*

C. Access to Services and Supports That Meet Individual Needs

Olmstead Decision Implementation Update

In August 2003, the 70-member Task Force formed pursuant to Item 329M of the 2002 Appropriation Act submitted its Final Report to the Governor, the Joint Commission on Health Care, and the Chairmen of the House Appropriations and Senate Finance Committees. The Report includes a vision statement, a goals statement, issues, and 201 recommendations with implementation time frames and responsible entities, organized by topic.

On January 6, 2004, Governor Warner issued Executive Order (EO) 61, "The Olmstead Initiative," establishing and specifying the responsibilities of a Community Integration Implementation Team comprised of 18 state agencies and four Secretariats, a Community Integration Oversight Advisory Committee comprised of a majority individuals with disabilities and family members and the balance comprised of advocates and providers, and a Director of Community Integration for People with Disabilities. Under EO 61, the Community Integration Implementation Team was charged to:

- Categorize recommendations into types of action needed to implement: administrative, regulatory, legislative and/or budget;
- Cost out and update recommendations; prioritize and prepare legislative and budget proposals for the Governor's consideration; and
- Seek advice from and report annually to the Committee on the status of *Olmstead* implementation in the Commonwealth

The Olmstead Advisory Committee's Second Annual Report to the Governor contained the following priorities.

TOP SIX PRIORITIES	
1	Increase all Medicaid reimbursement rates to include the maximum allowable cost of service; automatic cost of living adjustments (COLAs); geographical rate differentials; travel and transportation; staff training and supervision; and inflation. Ensure that caregiver pay rates are reflected. Reimburse Direct Support Professionals at higher pay and benefits for certifications and career enhancement. Increase rates for transportation services to

	adequately cover the cost of operations.
2	Increase the personal maintenance allowance to 300 percent of the monthly SSI payment limit in all Waivers.
3	Increase the availability of funded Medicaid Waiver slots for people on the urgent list as well as those wanting to leave institutions. Continue to eliminate waiting lists for Waivers and other supportive services; avoid future waiting lists by anticipating regular increases in need for services. Fund 25 percent of 2003 waiting list in 2005; 45 percent of 2004 waiting list in 2006; 65 percent of 2005 waiting list in 2007; 80 percent of 2006 waiting list in 2008; and 100 percent of waiting list, except those waiting 90 days or less, in 2009. Require DMAS to keep a waiting list of people in nursing facilities and ICFs/MR who are ready for discharge and who want to move. There should be no wait longer than 90 days for discharge for people living in any institution.
4	Continue to fund and develop community services to eliminate the state hospital discharge waiting lists.
5	Develop and fully fund incentives to attract and retain qualified candidates to disability fields of care.
6	Increase Medicaid financial eligibility to 100 percent of the Federal Poverty Level.

Community Capacity Development in Response to Documented Demand

Virginians with serious mental illnesses or emotional disturbances, mental retardation, or substance use disorders should receive high-quality treatment and services that:

- Are appropriate to the individual's service and support needs;
- Reflect the individual's choice and that of his family;
- Promote recovery, rehabilitation, and self-determination to the greatest extent possible;
- Provide positive outcomes; and
- Demonstrate cost-effectiveness.

Services should be provided in the most integrated setting appropriate to the needs of the individual. Services should build on, rather than replace, the individual's natural supports (family, friends, neighbors, churches, and other community organizations). This includes doing everything possible to keep the individual's family structure in place for as long as this is possible.

CSB Waiting Lists

The Department asked the CSBs to complete a point-in-time automated database to document the specific service requirements of individuals on CSB waiting lists in 2005. To be included in the database, an individual had to have sought a service from the CSB and been assessed by the CSB as needing that service. A summary of services needed and average service wait times by program area follow.

Numbers of Individuals on CSB Mental Health Services Waiting Lists by Service
January – April 2005

Service	Adult	C&A	Service	Adult	C&A
Outpatient Services					
Psychiatric Services	1,310	702	Intensive SA Outpatient (MI/SA)	248	34
Medication Management	1,356	690	Intensive In-Home		387
Counseling and Psychotherapy	1,756	1,058	Case Management	952	756
Assertive Community Treatment	370				

Service	Adult	C&A	Service	Adult	C&A
Day Support Services					
Day Treatment/Partial Hospitalization	289		Supported Employment Group Model	157	19
Rehabilitation	567	8	Transitional or Supported Employment	439	79
Therapeutic Day Treatment		302	Alternative Day Support Arrangements	247	156
Sheltered Employment	183	24			
Residential Services					
Highly Intensive (MH)	122	24	Supervised	318	41
Highly Intensive (SA Detox)	127	5	Supportive	710	72
Intensive	176	28	Family Support	255	494
Early/Infant-Toddler Intervention					
Infant and Toddler Intervention		49			

Of the children and adolescents on waiting lists for CSB mental health services, 1,684 were identified by the CSBs as currently needing specific services, 65 were identified as needing specific services beginning the 2008-2010 biennium, and 54 were identified as needing specific services beginning in the 2010-2012 biennium. Of these children and adolescents, 236 were in a Comprehensive Services Act mandated population and 1,024 were in a non-mandated population.

Additionally, there are currently 134 individuals in state hospitals whose discharges have been delayed due to extraordinary barriers.

April 2004

Service	Adult	C&A	Service	Adult	C&A
Outpatient Services					
Psychiatric Services	361	276	Intensive SA Outpatient	40	13
Medication Management	358	220	Intensive In-Home	0	122
Counseling and Psychotherapy	644	477	Case Management	164	262
Assertive Community Treatment	21	0			
Day Support Services					
Day Treatment/Partial Hospitalization	11	66	Supported Employment Group Model	6	1

Service	Adult	C&A	Service	Adult	C&A
Rehabilitation	25	0	Transitional or Supported Employment	15	1
Therapeutic Day Treatment	0	386	Alternative Day Support Arrangements	3	5
Sheltered Employment	7	0			
Residential Services					
Highly Intensive (MH)	6	2	Supervised	19	1
Highly Intensive (SA Detox)	58	0	Supportive	35	2
Intensive	3	3	Family Support	16	126
Early/Infant-Toddler Intervention					
Infant and Toddler Intervention	0	10			

CSBs also estimated the number of weeks individuals waited prior to their actual receipt of specific services. Average wait times across the 40 CSBs for specific mental health services follow. The longest service wait times were reported for residential services, with an average wait of about 4 months for supervised residential services.

Implementation of Evidence-Based and Best Practices

Evidence-based practices (EBPs) are those interventions that integrate the best research evidence with the best clinical expertise and values focused on individuals receiving services (Institute of Medicine Report Crossing the Quality Chasm, 2001). Evidence-based practices emphasizing individual participation, choice, recovery, and self-determined outcomes have the potential to significantly improve the quality of life for individuals receiving services.

The 1999 *Surgeon General's Report on Mental Health* prompted increased attention among policy-makers and payers to the issues associated with implementation of evidence-based practices in mental health. The Surgeon General's Report underscored that, for the most part, the effective interventions that exist for many mental disorders are simply not available to the majority individuals who could benefit from them. There are several evidence-based practices for the treatment of serious mental illnesses in adults and serious emotional disturbance in youth. These include:

For adults with serious mental illness:

- Co-Occurring Disorders: Integrated Dual Disorders Treatment
- Illness Management and Recovery
- Medication management Approaches in Psychiatry
- Family Psychoeducation
- Supported employment
- Assertive community treatment (ACT)

For children and adolescents with emotional disturbance or substance use disorders:

- Multi-systemic Therapy (MST)

- Functional Family Therapy (FFT)
- Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT)
- Integrated Community Treatment
- Therapeutic Foster Care
- Some prevention interventions.

Virginia has made significant progress in implementing selected evidence-based practices. For example, Programs of Assertive Community Treatment (PACT) have been developed in 15 CSB areas, and Multi-Systemic Therapy for adolescents is offered at several other CSBs. Most individuals have access to "new generation" medications, whether in CSB or state facility programs. Outcome data from the PACT initiatives have shown dramatic reductions in state hospital usage, increased stability in living situations for individuals, and reduced involvement with criminal justice agencies. The Department also supports family psycho-education through its contracts with family support groups and the Southwest Virginia Behavioral Health Board. Most individuals receiving services in the public mental health system, however, do not have consistent access to evidence-based services.

In FY 2005, the Department was awarded a three-year, $300,000 total, Real Choice Systems Change Grant from the Centers for Medicare and Medicaid Services (CMS) to support infrastructure development of the evidence-based practices for adults with serious mental illnesses. This grant is intended to align Virginia's existing community mental health Medicaid Rehabilitative Services with the evidence-based practices of assertive community treatment (ACT), illness management and recovery (IM&R), and supported employment (SE) and to maximize opportunities for peer specialists and peer-operated programs. Grant activities will follow a proven path to adopting and implementing evidence-based practices, consistent with Virginia's successful experience in implementing PACT teams. This will include a focus on consensus and partnership building with multiple stakeholders and constituencies to develop Virginia-specific models of IM&R and SE; regulatory analysis and clear articulation of Department, DMAS, and DRS funding streams that support PACT, IM&R, and SE services; provider training, consultation, and technical assistance; evaluation of implementation, measurements of fidelity to the models and individual outcomes; and plans to expand, sustain, and maintain a high level of quality services.

Recovery Orientation of Virginia's Public Mental Health System

Virginia has revised its vision statement to be:

Our vision is of a consumer-directed system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family and other meaningful relationships.

Legislative Initiatives/Changes

HB 110 Aging population; state agencies to prepare strategic plan on impact thereof, report.

Strategic plan; impact of aging population. Adds to the strategic plan that each state agency is required to prepare an examination of how the aging of the population will affect the agency's ability to deliver services and a description of how it is responding to these changes.

HB 1037 Sexually Violent Predators Services, Office of; established.

Sexually violent predators. Establishes within the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Office of Sexually Violent Predator Services to administer provisions relating to the civil commitment of sexually violent predators.

SB 182 Community Integration Advisory Commission; created.

Community Integration Advisory Commission. Establishes the Community Integration Advisory Commission to monitor the progress toward community integration of Virginians with disabilities by all executive branch state agencies.

HB 1062 Geriatric mental health services, specialized; DMHMRSAS to develop pilot program.

DMHMRSAS; pilot program for older adults with mental illness; report. Requires the DMHMRSAS to develop a two-year pilot program to provide specialized services for older adults (age 65 and older) who have serious mental illness.

SB 210 Mental health courts; Office of Executive Secretary of Supreme Court to establish.

Mental health courts; pilot program. Directs the Office of the Executive Secretary of the Supreme Court to establish by January 1, 2007, no less than two and no more than five mental health courts in Virginia for nonviolent offenders with serious

SB 211 Crisis intervention pilot prog.; to respond to crisis situations involving mental illness, report.

Crisis intervention pilot programs for persons with mental illness. Permits the Department of Criminal Justice Services to establish crisis intervention team pilot programs in up to six areas of the state by January 1, 2007.

B. Regional/sub-State programs, community mental health centers, and resources of counties and cities for provision of mental health services

Public community mental health, mental retardation, and substance abuse services are provided in Virginia by community services boards (CSBs), behavioral health authorities (BHAs), or local government departments with policy-advisory CSBs. All of these organizations function as:

- single points of entry into publicly funded mental health, mental retardation, and substance abuse services, including access to state hospital and training center (state facility) services;
- service providers, directly and through contracts with other providers;
- advocates for consumers[1] and other individuals in need of services;
- community educators, organizers, and planners;
- advisors to the local governments that established them; and

- local focal points for programmatic and financial responsibility and accountability.

Section 37.2-100 (§ 37.1-194.1) of the *Code of Virginia* defines three types of CSBs: operating CSBs, administrative policy CSBs, and policy-advisory CSBs with local government departments. Chapter 6 in Title 37.2 (chapter 15 in Title 37.1) of the *Code of Virginia* authorizes behavioral health authorities (BHAs) in three localities; a BHA now exists only in Richmond. In this overview, CSB or community services board means community services board, BHA, and local government department with a policy-advisory CSB, unless the context clearly indicates otherwise. In this Plan, the term CSB includes BHA.

CSBs are not part of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. While not part of the Department, CSBs are key operational partners with the Department and its state facilities in Virginia's system of public mental health, mental retardation, and substance abuse services. The Central Office, State Facility, and CSB Partnership Agreement, available at www.dmhmrsas.virginia.gov, describes this arrangement. Operating CSBs and BHAs are agents of the local governments that established them, but they are not city or county government departments. Most administrative policy CSBs are city or county government departments. The Department's relationships with all CSBs are based on the community services performance contract, applicable provisions in Title 37.2 of the *Code of Virginia*, and State Mental Health, Mental Retardation and Substance Abuse Services Board (State Board) policies and regulations. The Department contracts with, funds, monitors, licenses, regulates, and provides consultation to CSBs.

C. State mental health agency leadership in coordinating mental health services

Supporting System Collaboration and Integration

System Leadership Council

The System Leadership Council evolved from the FY 2001 Community Services Performance Contract negotiations, reflecting a desire to include a mechanism in the contract to provide continuity, enhance communications, and address and resolve systemic issues and concerns. The Department, pursuant to provisions in that Performance Contract, established the System Leadership Council in August 2000. The Council includes representatives of CSBs, state facilities, local governments, the State Board, and the Department's Central Office. Subsequent contracts from FY 2002 to the present have continued the Council. For FY 2004, the Council provisions were moved from the Performance Contract to the Central Office, State Facility, and Community Services Board Partnership Agreement. The Agreement states that the System Leadership Council shall, among other responsibilities:

- Identify, discuss, and resolve issues and problems;
- Examine current system functioning and identify ways to improve or enhance the operations of the public mental health, mental retardation, and substance abuse services system; and
- Identify, develop, propose, and monitor the implementation of new service modalities, systemic innovations, and other approaches for improving the accessibility, responsiveness, and cost

effectiveness of the publicly funded mental health, mental retardation, and substance abuse services system.

The Council serves as a coordinating mechanism to discuss issues and problems from a systemic point of view in a calm environment to reach as much agreement as it can, providing continuity, enhanced communication, and a consistent perspective over time. The Council's work and recommendations affect the organization and delivery of publicly funded services in the Commonwealth. The Council continues to discuss a broad range of issues and support various initiatives, including performance contract and reporting requirements, workforce concerns, aftercare pharmacy and medications issues, and discharge protocols and census management. For instance, the State Pharmacy Task Force established by the Council has significantly affected the operations of the pharmacy and the delivery of psychotropic medications across the state.

Services System Partnerships

The Department took a new approach in developing the FY 2006 Community Services Performance Contract. In collaboration with CSB representatives, Department staff developed the new contract from a blank slate, rather than just revising the previous year's contract. This produced a greatly shortened and more focused Performance Contract. It also produced two new documents, the Partnership Agreement and the Community Services Contract General Requirements Document. Full texts of all three documents are available on the Department's web site at www.dmhmrsas.virginia.gov.

The Partnership Agreement describes the values, roles, and responsibilities of the three operational partners in the public mental health, mental retardation, and substance abuse services system: CSBs, state facilities, and the Department's Central Office. It reflects the fundamental, positive evolution in the relationship between CSBs and the Department to a more collegial partnership. It recognizes the unique and complementary roles and responsibilities of the Department and the CSBs as the state and local authorities for the public mental health, mental retardation, and substance abuse services system. The goal of the Agreement is to establish a fully collaborative partnership process through which the CSBs, Central Office, and state facilities can reach agreements on operational and policy matters and issues.

Although this partnership philosophy helps to ensure positive working relationships, each partner has a unique role in providing public mental health, mental retardation, and substance abuse services. These distinct roles promote varying levels of expertise and create opportunities for identifying the most effective mechanisms for planning, delivering, and evaluating services.

Central Office

1. Ensures through distribution of available funding that a system of community-based and state facility resources exists for the delivery of publicly-funded services and supports to Virginia residents with mental illness, mental retardation, or alcohol or other drug dependence or abuse.
2. Promotes at all locations of the public mental health, mental retardation, and substance abuse service delivery system (including the Central Office) quality improvement efforts that focus on individual outcome and provider performance measures designed to enhance service quality, accessibility, and availability.
3. Supports and encourages the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.

4. Ensures fiscal accountability that is required in applicable provisions of the *Code of Virginia,* relevant state and federal regulations, and State Mental Health, Mental Retardation and Substance Abuse Services Board policies.
5. Promotes identification of state-of-the-art programming and resources that exist as models for consideration by other operational partners.
6. Seeks opportunities to affect regulatory, policy, funding, and other decisions made by the Governor, the Secretary of Health and Human Resources, the General Assembly, other state agencies, and federal agencies that interact with or affect the other partners.
7. Encourages and facilitates state interagency collaboration and cooperation to meet the service needs of consumers and to identify and address statewide interagency issues that affect or support an effective system of care.
8. Serves as the single point of accountability to the Governor and the General Assembly for the public system of mental health, mental retardation, and substance abuse services.
9. Problem solves and collaborates with a CSB and State Facility together on a complex or difficult consumer situation when the CSB and State Facility have not been able to resolve the situation successfully at their level.

Community Services Boards

1. Serve as the single points of entry into the publicly funded system of services and supports for Virginia residents with mental illnesses, mental retardation, or alcohol or other drug dependence or abuse.
2. Serve as the local points of accountability for the public mental health, mental retardation, and substance abuse service delivery system.
3. To the fullest extent that resources allow, promote the delivery of community-based-services that address the specific needs of individual consumers with a focus on service quality, accessibility, and availability.
4. Support and encourage the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.
5. Establish services and linkages that promote seamless and efficient transitions of consumers between state facility-based services and local community-based services.
6. Promote sharing of program knowledge and skills with operational partners to identify models of service delivery that have demonstrated positive consumer outcomes.
7. Problem solve and collaborate with State Facilities on complex or difficult consumer situations.
8. Encourage and facilitate local interagency collaboration and cooperation to meet the other services and supports needs of consumers.

State Mental Health Facilities

1. Provide psychiatric hospitalization and other services to consumers identified by CSBs as meeting statutory requirements for admission.
2. To the fullest extent that resources allow, provide services that address the specific needs of individual consumers with a focus on service quality, accessibility, and availability.
3. Support and encourage the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.

4. Establish services and linkages that promote seamless and efficient transitions of consumers between state facility-based services and local community-based services.
5. Promote sharing of program knowledge and skills with operational partners to identify models of service delivery that have demonstrated positive consumer outcomes.
6. Problem-solve and collaborate with CSBs on complex or difficult consumer situations.

Core Values

The partners entered into the Agreement to improve the quality of care provided to consumers and to enhance the quality of consumers' lives. While they are interdependent, each partner works independently with both shared and distinct points of accountability, such as state, local, or federal government, other funding sources, consumers, and families, and all partners embrace common core values. The following core values guide the operational partners in developing and implementing policies, planning services, making decisions, providing services, and measuring the effectiveness of service delivery.

1. The Central Office, state facilities, and CSBs are working in partnership; we hold each other accountable for adhering to our core values.
2. As partners, we will focus on fostering a culture of responsiveness instead of regulation, finding solutions rather than assigning responsibility, emphasizing flexibility over rigidity, and striving for continuous quality improvement, not just process streamlining.
3. As partners, we will make decisions and resolve problems at the level closest to the issue or situation whenever possible.
4. Services should be provided in the least restrictive and most integrated environment possible. Most integrated environment means a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible (28 CFR pt. 35, App. A, p. 450, 1998).
5. Community-based services and state facility-based services are integral components of a seamless public system of care.
6. The goal of all components of our public system of care is that the persons we serve recover, realize their fullest potential, or move to independence from our care.
7. The consumer's or legally authorized representative's participation in treatment planning and service evaluation is necessary and valuable and has a positive effect on service quality and outcomes.
8. The consumer's responsibility for and active participation in his or her care and treatment are very important and should be supported and encouraged whenever possible.
9. Consumers have a right to be free from abuse, neglect, or exploitation and to have their basic human rights assured and protected.
10. Choice is a critically important aspect of consumer participation and dignity, and it contributes to consumer satisfaction and desirable outcomes. Consumers should be provided with responsible and realistic opportunities to choose as much as possible.
11. Family awareness and education about a person's disability or illness and services are valuable whenever they are supported by the individual with the disability.
12. Whenever it is clinically appropriate, children and adolescents should receive services provided in a manner that supports maintenance of their home and family environment. Family includes single parents, grandparents, older siblings, aunts or uncles, and other individuals who have accepted the child or adolescent as a part of their families.

13. Children and adolescents should be in school and functioning adequately enough that the school can maintain them and provide an education for them.
14. Independent living or community residency in safe and affordable housing with the highest level of independence possible is desired for adult consumers.
15. Gaining employment, maintaining employment, or participating in employment readiness activities improves the quality of life for adults with disabilities.
16. Lack of involvement or a reduced level of involvement with the criminal justice system, including court-ordered criminal justice services, improves the quality of life of all individuals.
17. The public mental health, mental retardation, and substance abuse services system serves as a safety net for individuals, particularly people who are uninsured or under-insured, who do not have access to other service providers or alternatives.

Linkages with Local Government

The 134 cities or counties in Virginia continue to be vital members of the state-local partnership that enables the provision of community mental health, mental retardation, and substance abuse services to almost 200,000 Virginians annually. Local governments partner with the Commonwealth through the CSBs that they established and maintain and through their financial and other support of services offered by those CSBs. The Department needs to continue communicating with local governments through their CSBs about their concerns and ideas, such as ways to enhance service quality, effectiveness, and efficiency. As demands for services continue to exceed the capacity of the current services system to meet them and as related requirements for more effective management and coordination of services proliferate, new and innovative approaches need to be considered that preserve the strengths and advantages of the current public services system and the state-local partnership, while responding to these new demands.

Linkages with Private Providers

Private provider participation in the services system is another major strength of the public mental health, mental retardation, and substance abuse services system. This participation has grown dramatically over the last six years.

A number of conditions have limited, reduced or jeopardized private provider participation in the publicly funded mental health, mental retardation, and substance abuse services system.

- Medicaid State Plan Option and MR Waiver reimbursement rates, with only a few exceptions, have not been adjusted in over 13 years. In some areas of the state, Medicaid fees reportedly do not cover the cost of providing services; consequently, private providers are not able to offer those services on an economically sustainable basis.
- Third party insurance coverage for services continues to decline under managed healthcare, in terms of services covered, amounts of services allowed, and amounts paid for services.
- A growing proportion of individuals have inadequate or no health insurance coverage.
- Information about potential private providers may not be readily available to CSBs when their staffs are developing individualized services plans.
- There is a perceived or actual resistance by some private providers, especially residential or inpatient providers, to serving individuals receiving CSB services, because of the severity of the individuals' disabilities or lack on information about effective treatment modalities.

- Market forces have led to shifts in private sector service provision, despite the obvious and significant public sector needs for particular services. A clear and immediate example of this condition is the marked and continuing reduction in local private psychiatric inpatient hospital beds in some parts of the state that are available to CSBs and the Department. Some providers have ceased offering this service due to inadequate reimbursement rates; others have converted their inpatient beds to other uses, such as Comprehensive Services Act residential beds, which may be less costly to operate and more easily reimbursable.
- Like public providers, the private sector is experiencing increasing difficulties in recruiting and retaining qualified staff, including professionals, such as nurses and other clinical staff, and para-professionals, such as residential aides and personal care staff.
- The large capital cost sometimes associated with the implementation of new services, particularly residential services, may inhibit private sector participation.
- Finally, the significant start up costs, such as staff recruitment and training, equipment purchases, acquisition of space, and operating at less than full capacity during implementation that are often required to initiate a new service may make it difficult for smaller providers to do so, limiting their participation in the publicly-funded services system.

Interagency Relationships

The Report of the President's New Freedom Commission on Mental Health identified fragmentation as a serious problem at the state level. The Report stated that state mental health authorities have "enormous responsibility to deliver mental health care and support services, yet they have limited influence over many of the programs individuals and families need" (*Achieving the Promise: Transforming Mental Health Care in America*, p. 33). This fragmentation exists for mental retardation and substance abuse services and supports as well.

In an effort to overcome the inherent fragmentation resulting from existing organization and financing of federal and state programs providing services and supports to individuals receiving mental health, mental retardation, and substance abuse services, the Department maintains collaborative linkages, partnerships, and activities with a number of state agencies. These include the Department of Housing and Community Development (DHCD), Department of Rehabilitative Services (DRS), the Department of Medical Assistance Services (DMAS), the Department of Social Services (DSS), the Department of Corrections (DOC), the Department of Criminal Justice Services (DCJS), the Department of Juvenile Justice (DJJ), the Virginia Department of Health (VDH), the Department for the Blind and Visually Impaired (DBVI), the Department for the Deaf and Hard of Hearing (DDHH), the Department of Education (DOE), the Virginia Employment Commission (VEC), the Virginia Office for Protection and Advocacy (VOPA), the Virginia Housing Development Authority (VHDA). In addition, Virginia has applied for the Mental Health Transformation State Infrastructure Grant. Following are descriptions of major interagency collaborative activities.

Interagency Councils and Partnerships

Virginia Board for People with Disabilities – The Department is a member of this Board, which is the state's Developmental Disabilities Council and is responsible for reporting to the Governor on a variety of disability issues. The Board also funds ongoing programs such as the Youth Leadership Forum and Partners in Policy Making, both designed to prepare individuals and families to understand disability services systems and become advocates.

Commission on Youth – The Department actively participates on legislative study committees of the Commission on Youth. In the past year the Commission disseminated the *Collection of Evidence Based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs.* This document is being electronically disseminated across Virginia to families and public and private providers to increase utilization of evidence based services and practices in child and adolescent mental health treatments. This document may be accessed through www.coy.state.va.us.

Comprehensive Services Act (CSA) – The DMHMRSAS Commissioner is a member of the State Executive Council, which meets monthly and sets policy for community services provided pursuant to the Comprehensive Services Act for At Risk Youth and Families (CSA). Department staff are active participants in the State and Local Advisory Team, which is charged in the *Code of Virginia* §2.1-747 with advising the State Executive Council on state and local CSA operations and service delivery. The Department and other state agency participants provide administrative support for the team in the development and implementation of the collaborative system of services and funding authorized under the CSA. This Team meets at least quarterly. A second CSA team, the Training and Technical Assistance Team, assists local and regional communities in planning and developing training to meet the needs of children and families and systemic needs of local agencies. This team meets at least quarterly to determine training needs.

Mental Health Planning Council - This Council, required by P.L. 102-321 as a condition of Community Mental Health Services Block Grant funding, was initially created in 1989. The Council serves as an advocate for adults with serious mental illness and children with serious emotional disturbance and is authorized in P.L. 102-321 to review, monitor, and evaluate the state's mental health system. The Council has 35 members, including mental health individuals, family members, parents of children with serious emotional disturbances, representatives of key state agencies, state mental health facilities, and major mental health advocacy groups. In addition to functioning in an advisory capacity to the Department, the Council guides the Department in developing individual and family education and manages a small budget of $25,000 that is used to support Council activities, including an annual retreat. Each year, the Council prepares an annual report and recommendations to the state, which is submitted to the Center for Mental Health Services as part of the Department's federal block grant application.

Substance Abuse Services Council – This Council, established by the *Code of Virginia*, § 37.1-207, consists of agency directors (or their delegates) representing the Department, VDH, DSS, DOE, DOC, DJJ, DCJS, the Commission on Alcohol Safety Action Programs, four members of the House of Delegates, two members of the Senate, and representatives from key groups engaged in substance abuse issues (i.e., the VACSB, the Substance Abuse Certification Alliance of Virginia, the Virginia Association of Alcoholism and Drug Abuse Counselors the Virginia Association of Drug and Alcohol Programs the Virginia Sheriff's Association, and the advocacy community). The Council advises and makes recommendations to the Governor, the General Assembly, and the State Board on broad policies and goal and on the coordination of Virginia's public and private efforts to control alcohol and other drug abuse. In preparation for a formal report and interagency plan to be presented to the Governor and the General Assembly, the Council conducted a survey of state agencies and held five focus groups throughout Virginia to identify critical issues and trends in substance abuse. Critical issues identified include the need for advocacy and education, enhanced collaboration, additional funding, leadership, and service system issues such as access, capacity, continuum of care, and quality of care. This plan was presented to the Governor and the General Assembly in the Fall of 2003. The Council maintains a website at http://www.dmhmrsas.virginia.gov/SASC/

Governor's Office for Substance Abuse Prevention (GOSAP) – The Department is actively involved with the Governor's Office for Substance Abuse Prevention (GOSAP), a federal-state initiative funded by the SAMHSA Center for Substance Abuse Prevention. Housed in the Office of the Secretary of Public Safety, GOSAP brings together the Department, VDH, DCJS, DOE, DSS, DJJ, the Department of Motor Vehicles, the Department of Alcoholic Beverage Control, and the Tobacco Settlement Foundation to coordinate Virginia's substance abuse activities for efficient and effective use of resources. GOSAP administers the CSAP State Incentive Grant and the Governor's discretionary portion of the Safe and Drug Free Schools Act grant. GOSAP maintains a website at www.gosap.virginia.gov.

Early Intervention (Part C) Interagency Management Team – The Part C Program is an interagency endeavor with an interagency management team as established in *Virginia Code*. This team has representation from the DBVI, DDHH, DSS, VDH, DOE, DMAS, VOPA, and the State Corporation Commission. A representative from the Virginia Association of Community Services Boards also participates with the team. This group guides the program direction in accordance with federal and state policies.

Virginia Advisory Committee on Juvenile Justice – The DCJS Juvenile Services Section, administers three primary juvenile justice federal funding streams allocated to Virginia. In 1994, DCJS implemented a strategy to use these funds along the continuum of juvenile justice, from prevention through community-based interventions to secure confinement. The three funds are: Title V and II of the Juvenile Justice and Delinquency Prevention (JJDP) Act and the Juvenile Accountability Incentive Block Grant (JAIBG) programs. These funds are intended to address the problem of juvenile crime by promoting greater accountability in the juvenile justice system. This Advisory Committee sets priorities for spending, reviews state and local grants, and makes plans to improve juvenile services in Virginia. The Department actively participates in the fall, winter, and spring meetings of the Virginia Advisory Committee on Juvenile Justice. During FY 2002 and FY 2003, the Advisory Committee established mental health services to juvenile offenders as a priority for spending. Many children in Virginia's juvenile justice system have demonstrated mental heath needs. An analysis of juveniles committed to the State's correctional facilities indicated that, in 1998, 47 percent of males and 57 percent of females had identified mental health treatment needs. They also reported a history of substance abuse. (Source: Virginia's Three-Year Plan 2003-2005, Juvenile Justice and Delinquency Prevention Act, the Juvenile Services Section, Department of Criminal Justice Services.) With this priority designation, CSBs and the Department were able to apply for funds to meet the mental health needs of juveniles and juvenile offenders. In July 2003, the Department received a one-year grant award from the DCJS of $549,825 (including a local and state match) to provide a mental health clinician and case manager in five detention centers. Funds were distributed to five CSBs to provide mental health treatment services, psychiatric evaluations and substance abuse services to juvenile offenders in need of these services.

Virginia Intercommunity Transition Council – This Council promotes successful transition outcomes for youth and young adults with disabilities by providing leadership and innovation in planning and developing services across agencies to meet their employment, education, training, and community services and supports needs. Youth with serious emotional behaviors face many new challenges when they reach young adulthood, including burdens related to seeking employment and advanced education and training and maintaining community life. Far too often, these youth become homeless or unemployed, drop out of school, or end up in the correctional system. In the past year, the Department collaborated with DOE and DRS to provide training to parents, counselors, teachers, and providers to develop and provide comprehensive community-based

services to young adults. The VITC will continue to provide technical assistance related to transition planning for these young adults.

Program Improvement Plan Committee of the Child and Family Services Review Task Force – The 1994 Amendments to the Social Security Act authorized the U.S. Department of Health and Human Services to review State child and family services programs in order to ensure substantial conformity with the State plan requirements in titles IV-B and IV-E or the Social Security Act. The reviews cover child protective services, foster care, adoption, family preservation and family support, and independent living. The reviews are designed to help states improve child welfare services and outcomes for families and children who receive services by identifying strengths and needs within state programs, as well as areas where technical assistance can lead to program improvements. To prepare for the federal audit, DSS organized a Task Force of state and local agencies and family organization to conduct a 6-month assessment of the state's programs before the review, determine the sites, and serve as an advisory committee for the development of the Program Improvement Plan after the review. A representative from the Department and the Child and Family Council of the VACSB serve on this Task Force, which meets monthly.

Virginia's review was held during the week of July 7- 11, 2003. The review examined seven outcomes across three domains: safety, permanency, and child and family well being. Virginia's preliminary results indicated nonconformity in meeting the mental health needs of children in child welfare. This outcome failure presents an opportunity for improved services and collaboration between CSBs and local social services departments. The DSS must develop a Program Improvement Plan (PIP) that covers all areas of nonconformity within 90 calendar days of receiving the written notices of nonconformity. During September and October 2003, DSS reviewed the preliminary results with all 130 local social services departments in order to engage their participation in the development of the Improvement Plan. These local departments must conform to the approved PIP. If the State fails to make improvements needed to bring areas of non-conformity into substantial conformity, federal funds are withheld commensurate with the level of the nonconformity. Many of the children in the child welfare system receive services through the CSBs.

Child Fatality Review Team – The Department has continued to serve on the State Child Fatality Review Team, established pursuant to the *Code of Virginia* §32.1-283.1 B. This 16-member Team develops and implements procedures to ensure that child deaths occurring in Virginia are analyzed in a systematic way. Team recommendations are used to develop procedures for the review of child deaths; improve the identification, data collection, and record keeping of the causes of child deaths; recommend components for a prevention and education program; recommend training; improve the investigations for child deaths; and provide technical assistance, upon request, to any local child fatality teams that may be established. Team recommendations are used for public health planning, prevention programming, and policy discussions and recommendations. From 1995 - 2001, the Team reviewed child deaths due to firearms, suicide, and unintentional injury. In December 2002, the Committee completed a report on 2001 child deaths due to unintentional injury, suicide, homicide, and natural or undetermined causes. For 2003-2005, the Team will review child deaths related to vehicular violence. The Team meets bimonthly at the Office of the Medical Examiner.

Commonwealth Partnership for Women and Children Affected by Substance Use – The Partnership's membership consists of representatives from VDH, DOE, DSS, DOC, CSBs and contract providers, local departments of social services and health, local housing authorities, the Medical College of Virginia, provider associations, the faith community, and local nonprofit agencies, all organizations that provide services for women and children whose lives have been affected by substance use. The Partnership seeks to identify and resolve barriers to services by

seeking resources, encouraging interagency collaboration, participating in community planning and policy development, and coordinating education and training events.

[1] Pires, Sheila A., Building Systems of Care: A Primer, 2002

[2] Multisystemic therapy http://www.mstservices.com

[3] Functional family therapy http://www.omh.state.ny.us/omhweb/ebp/children_fft.htm